1. Purpose
   The purpose of this policy is to establish criteria for the medical necessity of the use of mechanical spinal traction.

2. Definitions
   2.1. “Mechanical Spinal Traction” is the process of applying an axial force to the spinal column through body weight, weights, pulleys and/or automated devices to distract the spine. The use of spinal traction devices requires supervision and should be reported for each 15 minute time period.

   2.2. “Non-Surgical Spinal Decompression” (a.k.a., Vertebral Axial Decompression or Spinal Decompression Treatment) is a form of mechanical spinal traction that has reportedly been designed to temporarily reduce intradiscal pressure and relieve low back pain or neck pain associated with herniated discs or degenerative disc disease. Non-surgical spinal decompression therapy includes, but is not limited to the use of the following treatment tables VAX-D®, Accu-SPINA™, DRX 2000, DRX3000, DRX5000, DRX-9000®, DRX-9000C®, DRX9500®, Chattanooga Triton® DTS, ATX Tables, the Axiom Worldwide DRX9000™, the DRS (Decompression Reduction Stabilization) System®, DRX, the Alpha-SPINA System™, the Dynatron DX2™, the Lordex® Lumbar Spine System, the Saunders 3D ActiveTrac®, Spinerx LDM, TruTac 401, NuChoice Medical Healthstar Elite Decompression Therapy, Antalgic-Trak, the Cert Health Sciences Spine MED, or Internal Disc Decompression (IDD) Therapy, also known as Intervertebral Differential Dynamics Therapy, etc. This list should not be considered all inclusive.

3. Statement of Policy
   3.1. The determination of medical necessity for the use of spinal traction is always made on a case-by-case basis.

   3.2. The use of mechanical spinal traction has been demonstrated in a sub-group of patients characterized by the presence of leg symptoms, signs of nerve root compression, and either peripheralization (increased leg pain) with lumbar extension movements or a crossed straight leg raise. The use of mechanical spinal traction may be considered medically necessary for a patient who has pain with radicular findings. Based on the fact that the perceived benefits are short-term in nature, the goal in the
use of mechanical traction should be to decrease pain in order to facilitate participation in active rehabilitative care (e.g., office or home based therapeutic exercises and other functional activities).

3.3. The scientific evidence for the long-term efficacy of spinal traction is lacking, limited or conflicting. As a result, intermittent or continuous traction as a single treatment for patients with low back pain or neck pain with radiculopathy may be considered not medically necessary.

3.4. Based on the results of the available scientific studies involving mixed groups of patients with acute, sub-acute and chronic neck pain or low back pain without radicular findings, intermittent or continuous traction for patients presenting with neck pain or low back pain without radiculopathy is not considered effective for this group and consequently may be considered not medically necessary.

3.5. There is limited evidence of efficacy by different forms of traction for neck pain with radiculopathy, in particular when combined with manual therapy and specific rehabilitative exercises. Triad Healthcare, Inc. recognizes that during the first two to three (2-3) weeks of care, the patient’s may report clinically relevant short-term improvements in their pain and functional levels as well as improved patient satisfaction with the use of intermittent mechanical cervical traction. The use of intermittent mechanical cervical traction in patients presenting with neck pain with cervical radiculopathy therefore may be considered medically necessary.

3.6. Any treatment plan involving spinal traction should ultimately result in a reduction in the patient’s pain and/or an improved ability to carry out usual activities of daily living. The use of mechanical traction beyond two to three (2-3) weeks without a clinically meaningful reduction in the patient’s pain levels, the reduction in use of medication or medical services and/or clinical signs of functional improvement may be considered not medically necessary.

Note: This policy pertains to mechanical traction (including spinal decompression devices), gravity-dependent (“anti-gravity”) traction, pneumatic traction, motorized traction, continuous traction, and intermittent traction as well as other forms of traction not included in this list. For the purposes of this policy, mechanical devices which provide intersegmental mobilization rather than significant axial distraction forces (including Spinalator, Anatamotor, etc.) are not considered forms of mechanical traction. Certain types of traction may be
considered experimental or investigational, and may be excluded from coverage in accordance with corresponding health plan policy.

3.7. Triad considers Vertebral Axial Decompression or Spinal Decompression Treatment (e.g., by means of the VAX-D Table, the Accu-SPINA™ System, DRX2000, DRX3000, DRX5000, DRX-9000, DRX-9000C, DRX9500, Chattanooga Triton® DTS, ATX Tables, the Axiom Worldwide DRX9000™, the DRS (Decompression Reduction Stabilization) System, DRX, the Alpha-SPINA System™, the Dynatron DX2™, the Lordex® Lumbar Spine System, the Saunders 3D Active Trac®, Spinex LDM, TruTac 401, NuChoice Medical Healthstar Elite Decompression Therapy, Antalgic-Trak, the Cert Health Sciences Spine MED, or Internal Disc Decompression (IDD) Therapy, also known as Intervertebral Differential Dynamics Therapy; etc.) experimental and investigational. Currently there is not adequate scientific evidence to prove that vertebral axial decompression is an effective adjunct to conservative therapy for back pain and have not been adequately studied as alternatives to back surgery.

4. References

4.1. Scientific:

The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding traction for the treatment of spinal and radicular pain syndromes and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the information can be reviewed by the Academic Advisory Committee (AAC) and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.


• US Department of Health and Human Services, Health Care Financing Administration (HCFA), HCFA Technology Advisory Committee Minutes, August 6-7, 1996.


4.2. Related Triad Medical Policies:

- TMMP 18 - Medical Necessity
- TMMP 10 - Use of Passive and Active Care
- TMMP 13 – Use of Adjunctive Modalities and/or Therapeutic Procedures
CPT Codes
This policy relates to the use of the following CPT Codes:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description (AMA CPT Guide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>97012</td>
<td>Application of a modality to 1 or more areas; traction, mechanical.</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes.

Table of Revisions

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/24/2014</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. §2.2. “Non-Surgical Spinal Decompression” text added: “Non-surgical spinal decompression therapy includes, but is not limited to the following treatment tables VAX-D®, Accu-SPINA™, DRX 2000, DRX3000, DRX5000, DRX-9000®, DRX-9000C®, DRX9500B®, Chattanooga Triton® DTS, ATX Tables, the Axiom Worldwide DRX9000™, the DRS (Decompression Reduction Stabilization) System®, DRX, the Alpha-SPINA System™, the Dynatron DX2™, the Lordex® Lumbar Spine System, the Saunders 3D ActiveTrac®, Spinerex LDM, TruTac 401, NuChoice Medical Healthstar Elite Decompression Therapy, Antalgic-Trak, the Cert Health Sciences Spine MED, or Internal Disc Decompression (IDD) Therapy, also known as Intervertebral Differential Dynamics Therapy, etc.” §3.7. text added: “Triad considers Vertebral Axial Decompression or Spinal Decompression Treatment (e.g., by means of the VAX-D Table, the Accu-SPINA™ System, DRX2000, DRX3000, DRX5000, DRX-9000, DRX-9000C, DRX9500B, Chattanooga Triton® DTS, ATX Tables, the Axiom Worldwide DRX9000™, the DRS (Decompression Reduction Stabilization) System, DRX, the Alpha-SPINA System™, the Dynatron DX2™, the Lordex® Lumbar Spine System, the Saunders 3D ActiveTrac®, Spinerex LDM, TruTac 401, NuChoice Medical Healthstar Elite Decompression Therapy, Antalgic-Trak, the Cert Health Sciences Spine MED, or Internal Disc Decompression (IDD) Therapy, also known as Intervertebral Differential Dynamics Therapy; etc.) experimental and investigational. Currently there is not adequate scientific evidence to prove that vertebral axial decompression is an effective adjunct to conservative therapy for back pain and have not been adequately studied as alternatives to back surgery.” §4.1. updated with additional scientific references.</td>
</tr>
<tr>
<td>06/10/2013</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. §2.2 updated to include ® mark for the now registered Chattanooga Triton® DTS. Other formatting changes completed.</td>
</tr>
<tr>
<td>08/06/2012</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Removed CPT code from title and added CPT table.</td>
</tr>
<tr>
<td>05/20/2011</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>03/18/2010</td>
<td>Level 1, 2, 3</td>
<td>Annual review. No changes made to policy text.</td>
</tr>
<tr>
<td>02/18/2009</td>
<td>Level 1, 2, 3</td>
<td>Policy revised to include definition of Non-Surgical Spinal Decompression. Section 3.4 updated to reflect results of the available scientific studies.</td>
</tr>
<tr>
<td>08/17/2008</td>
<td>Level 1, 2, 3</td>
<td>New medical policy.</td>
</tr>
</tbody>
</table>
Triad’s Medical Policies are not recommendations for treatment and providers are expected to exercise their clinical judgment in providing the most appropriate care. Health care providers and patients should not rely on these Medical Policies in making health care decisions. These Medical Policies are guidelines and do not constitute an authorization, certification, explanation of benefits or guarantee of payment. Applications of Triad’s Medical Policies are determined by the enrollee’s benefit documents and contracts and as such individual benefits must be verified. Determinations of medical necessity apply only if the benefit exists and no contract exclusions are applicable. In the event of a conflict, a participant’s benefit plan document shall supersede the information contained in Triad’s Medical Policies.